

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07481								07474	
1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Chester</i> c. LENGTH OF STAY IN 1b <i>Life</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Chester</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>Tobithia</i> Middle <i>E.</i> Last <i>Crouch</i>			4. DATE OF DEATH Month <i>May</i> Day <i>1</i> Year <i>19 66</i>						
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 22, 1888</i>		9. AGE (In years last birthday) <i>77</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Mln.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Queen Anne, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Franklin Jones</i>			14. MOTHER'S MAIDEN NAME <i>Carrie Johnson</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Gerald Crouch--Annapolis, Maryland</i>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> <i>4201</i> DUE TO (b) <i>Hypertensive, Arteriosclerotic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Cardio-Vascular Disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH <i>Immed.</i> <i>15 yrs.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 1951, to <i>April</i> , 1966, that (I) (was) last saw the deceased alive on <i>April 29</i> 1966, and that death occurred at <i>1A</i> M., from the causes and on the date stated above.									
22a. SIGNATURE <i>Irvin G. Hoyt</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5-2-66</i>				
22c. PHYSICIAN'S NAME (Type) <i>G. Irvin Hoyt</i>			22d. ADDRESS <i>Queenstown, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 3</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Stevensville</i>		23d. LOCATION (City, town or county) (State) <i>Stevensville Maryland</i>			
24. FUNERAL DIRECTOR <i>Edgar L. Lane</i>			ADDRESS <i>Church Hill, Maryland</i>		25a. REC'D BY REGISTRAR <i>MAY 6 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

1947

1947

Dear Sir,
I have the pleasure to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
[Signature]

At the County of [County Name] Court
this [Date] day of [Month], 1947.
[Signature]
[Title]

Witness my hand and seal this [Date] day of [Month], 1947.
[Signature]
[Title]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07482 Item 1d Film 3277 5/26/66 07475											
1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>QUEEN ANNE'S</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u> 17-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RFD #1, Box 138</u>						d. STREET ADDRESS <u>RFD #1 Box 138</u>					
3. NAME OF DECEASED (Type or print) First <u>Sarah Elizabeth</u> Middle <u>Embert</u> Last <u>Embert</u>						4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 28, 1875</u>		9. AGE (In years last birthday) <u>90</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Centreville, Q.A.C., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Josiah Eaton</u>						14. MOTHER'S MAIDEN NAME <u>Mollie Draper</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-52-9006</u>		17. INFORMANT <u>Mrs. O. Rafield Tarr, Centreville, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>10 years.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>3.6 hours</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>66</u> , to <u>May 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 1</u> , 19 <u>66</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>John R. Smith, Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>5-20-66</u>											
22c. PHYSICIAN'S NAME (Type) <u>John R. Smith, Jr.</u> 22d. ADDRESS <u>Centreville, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>MAY 20, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>CENTREVILLE, MARYLAND</u>											
24. FUNERAL DIRECTOR <u>James H. Butler, Jr., Butler Bros., Centreville, Md.</u> 25a. REC'D BY REGISTRAR <u>MAY 23 1966</u> 25b. REGISTRAR'S SIGNATURE <u>g. Charles Judge</u>											

35219

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1000

200

Control Sheet

1890-1891

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Lycopodium obscurum

[illegible]

22

11-1784

1



10

2-X-2

John R. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u> 17-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First <u>GOLDEN</u> Middle <u>MOSSMAN</u> Last <u>MOSSMAN</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1966</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 22 - 1887</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH SCOGGINS</u>						14. MOTHER'S MAIDEN NAME <u>ELMA MYERS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <u>JUNE MARKWELL - LAKEWOOD OHIO</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 170X DUE TO (b) <u>Metastatic Carcinoma from Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Carcinoma of Breast arteriosclerotic Heart Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>12 hour</u> <u>1 year</u> <u>4 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>66</u> , to <u>May 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 26</u> 19 <u>66</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>John R Smith Jr</u>						22b. DATE SIGNED <u>5-30-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>JOHN R. SMITH JR.</u>						22d. ADDRESS <u>CENTREVILLE MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>JUNE 1</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKES</u>		23d. LOCATION (City, town or county) (State) <u>CHURCH HILL MD.</u>			
24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>						ADDRESS <u>CHURCH HILL, MD.</u>		25a. REC'D BY REGISTRAR <u>JUN 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Central American
University
Buenos Aires

John R. Smith
for

University of Buenos Aires
Buenos Aires, Argentina

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Queen Anne's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millington c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millington d. STREET ADDRESS 17-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sadie		First M.		Middle Robbins		Last		4. DATE OF DEATH Month May Day 17 Year 19 66	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 10, 1896		9. AGE (in years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. George.					14. MOTHER'S MAIDEN NAME Ella Morris				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.				16. SOCIAL SECURITY NO. 222-14-2713		17. INFORMANT Mrs. Anna Coppage, Millington, Md. 21651			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 260X DUE TO (b) Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Diabetes								INTERVAL BETWEEN ONSET AND DEATH One day 4 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from May 17, 1966 to May 17, 1966 , that I (we) last saw the deceased alive on May 16, 1966 , and that death occurred at 5 P M, from the causes and on the date stated above.									
22a. SIGNATURE Geza Koralewski						22b. DATE SIGNED May 18, 1966		22c. PHYSICIAN'S NAME (Type) Geza Koralewski. M.D.	
22d. ADDRESS Millington, Md. 21651									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May, 20, 1966		23c. NAME OF CEMETERY OR CREMATORY Millington Cemetery		23d. LOCATION (City, town or county) (State) Millington, Md. Md.			
24. FUNERAL DIRECTOR Edward Kellon Millington Md.						25a. REC'D BY REGISTRAR MAY 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

Enslai

May, 20, 1955

Millington Court 17

Millington, Md.

Md.

Gene Foxworth, M.D.

Millington, Md. 21551

Copy furnished

Robert

(Living in)

Living in

No.

215-1-2115

Mrs. Anne Foxworth

Millington, Md. 21551

John E. George

Elia Morris

Honorable

Our Home

Del.

Female White

x

November 10, 1955

Robbie

M.

Radio

Millington

Canon Anne's

Millington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07485											
07479											
1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>QUEENSTOWN</u>						c. LENGTH OF STAY IN 1b <u>All his life</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS <u>QUEENSTOWN</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Spencer Thomas Smith</u>						4. DATE OF DEATH Month Day Year <u>May 1 1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24, 1893</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAIRY MAINTENANCE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>QUEEN ANNE'S Co., MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ezekiel Smith</u>						14. MOTHER'S MAIDEN NAME <u>CLARA Callahan</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-20-0091</u>		17. INFORMANT Address <u>MRS. MARGARET C. Smith, Queenstown, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Thyroid with</u> <u>194X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>widespread metastases</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> <u>1966</u> to <u>April</u> <u>1966</u> that (I) (we) last saw the deceased alive on <u>April 30</u> <u>1966</u> , and that death occurred at <u>7:05</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Kevin G. Hoyt</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/3/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Kevin G. Hoyt M.D.</u>						22d. ADDRESS <u>Queenstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>CENTREVILLE, MARYLAND</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Donald H. Bantz Jr.</u>				ADDRESS <u>Centerville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

1913

State of New York
County of ...
In SENATE
January 22, 1913

Report of the
Commissioner of the
Department of
Conservation
for the year
1912

Approved by the
Senate
January 22, 1913
Attest
Secretary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07486

07480

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> c. LENGTH OF STAY IN 1b <u>1 yr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>334 Commerce St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Queen Anne</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> d. STREET ADDRESS <u>334 Commerce St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Lula Wilkerson</u> First Middle Last 4. DATE OF DEATH <u>5-22-1966</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-24-1913</u> 9. AGE (in years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>HARVEY JOHNSON</u> 14. MOTHER'S MAIDEN NAME <u>GERTRUDE GRIFPIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>28-20-567</u> 17. INFORMANT <u>CARL WILKERSON</u> Address <u>CENTERVILLE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinosis of</u> <u>171X</u> DUE TO <u>Abdomen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Primary of Cervix</u> DUE TO (c) <u>4 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 23, 1962</u> to <u>May 24, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 21, 1966</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>C.R. Layton</u> 22c. PHYSICIAN'S NAME (Type) <u>C.R. Layton</u>		22b. DATE SIGNED <u>5-24-66</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Centerville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>5-26-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>CARMICHAEL CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>Queentown Md.</u>		24. FUNERAL DIRECTOR <u>James B. Dashiell</u> ADDRESS <u>Easton, Md</u> 25a. REC'D BY REGISTRAR <u>MAY 26 1966</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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